TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Michael S. Johnson, D.C.

Respondent Name
Union Insurance Company

MFDR Tracking Number
M4-17-2492-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 20, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Claim was not paid in full and was reduced due to charges exceed your contracted arrangement … **Texas Labor Code §408.0041 requires insurance carrier to reimburse designated doctors for examinations ordered by the Commissioner of Workers' Compensation.**"

Amount in Dispute: $170.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the attached. The carrier has paid the amount in dispute."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 11, 2017	Designated Doctor Examination	$170.00	$170.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides requirements for medical reimbursement.
3. 28 Texas Administrative Code §134.235 sets out the fee guidelines for examinations to determine return to work and evaluation of medical care performed on or after September 1, 2016.
4. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating performed on or after September 1, 2016.
5. Texas Labor Code §408.0041 grants the Division of Workers' Compensation the authority to order designated doctor examinations.

6. Texas Insurance Code §1305 puts forth the requirements for claims subject to certified health care networks.
7. Union Insurance Company reimbursed $680.00 and reduced the requested payment for the disputed services with the following claim adjustment codes:
   - 45 – Charges exceed your contracted/legislated fee arrangement.
   - Note: "IF APPLICABLE, NETWORK DISCOUNTS APPLIED IN ACCORDANCE WITH YOUR AGREEMENT WITH THE COMPKEY PLUS HCN NETWORK, 13765019."
   - W3 – Additional payment made on appeal/reconsideration.

Issues

1. Are the services in question subject to network reduction?
2. Is Michael S. Johnson, D.C. entitled to additional reimbursement for the services in question?

Findings

1. Dr. Johnson is seeking an additional reimbursement of $170.00 for a designated doctor examination to determine maximum medical improvement and the ability of the injured employee to return to work. Union Insurance Company reduced the disputed services with claim adjustment reason code 45 – "CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT," adding the additional note, "IF APPLICABLE, NETWORK DISCOUNTS APPLIED IN ACCORDANCE WITH YOUR AGREEMENT WITH THE COMPKEY PLUS HCN NETWORK, 13765019."

   Designated doctor examinations are authorized under the Texas Labor Code and division rules. Texas Labor Code §408.0041 grants the division the exclusive authority to order a designated doctor to examine an injured employee and resolve questions or disputes over the injured employee's medical condition.

   28 Texas Administrative Code §134.1 requires that reimbursement of examinations ordered under Texas Labor Code §408.0041 is to be in accordance with 28 Texas Administrative Code §134.204, replaced as applicable by 28 Texas Administrative Codes §§134.235 through 134.250.

   Because the service in question was provided under the authority of the Texas Labor Code and not under a certified health care network, the division concludes that the services in question are not subject to network reduction.

2. Per 28 Texas Administrative Code §134.250(2)(A),

   > If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection. Modifier "NM" shall be added.

   Paragraph (3) states, "The following applies for billing and reimbursement of an MMI evaluation… (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation supports that Dr. Johnson performed an evaluation of MMI and found that the injured employee was not at MMI. Therefore, the maximum allowable reimbursement (MAR) for this examination is $350.00.

   28 Texas Administrative Code §134.235 states, in relevant part:

   > The following shall apply to return to work (RTW)/evaluation of medical care (EMC) examinations. When conducting a division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT code 99456 with modifier "RE." In either instance of whether maximum medical improvement/ impairment rating (MMI/IR) is performed or not, the reimbursement shall be $500 in accordance with §134.240 of this title and shall include division-required reports…

   The submitted documentation indicates that Dr. Johson performed an examination to determine the ability of the injured employee to return to work. Therefore, the correct MAR for this examination is $500.00.

   The total MAR for the disputed services is $850.00. Union Insurance Company paid $680.00. An additional reimbursement of $170.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $170.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $170.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	June 9, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.